. No. 300
. 10-48

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#94257

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 6185

BIRTH NO. _____ REG. DIST. NO. 618 PRIMARY REG. DIST. NO. 1003 Registrar's No. 1101

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Louis, Missouri.
c. LENGTH OF STAY (In this place) 0
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Louis City Hospital #1.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri
b. COUNTY Texas 107
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Houston
d. STREET ADDRESS (If rural, give location) Route 1

3. NAME OF DECEASED (Type or Print)
a. (First) LOVENE
b. (Middle)
c. (Last) FULK

4. DATE OF DEATH (Month) (Day) (Year) February 3, 1949

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married

8. DATE OF BIRTH March 10, 1930

9. AGE (In years last birthday) 18
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Missouri

12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME Mack Fulk

13b. MOTHER'S MAIDEN NAME Ethel Ice

14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Ethel Fulk, Houston, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) MEASLES & ENCEPHALITIS — INTERVAL BETWEEN ONSET AND DEATH: 8 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) MENINGOCOCCEMIA — 3 days
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Lower Nephron Nephrosis — 1 day

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that, I attended the deceased from* 2/2/49, 19__, *to* 2/3/49, 19__, *that I last saw the deceased alive on* 2/3/49, 19__, *and that death occurred at* 5:15 PM *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) Jacob L. Bolen M.D.

23b. ADDRESS 1515 Lafayette Ave.,

23c. DATE SIGNED 2/4/49

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 2-6-49

24c. NAME OF CEMETERY OR CREMATORY

24d. LOCATION (City, town, or county) (State) Cabool, Mo.

DATE REC'D BY LOCAL REGISTRAR FEB 4

REGISTRAR'S SIGNATURE J. B. Lawter

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe, 4700 Washington Blvd.

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Student Embalmer No. .....,

working under my personal supervision.

Signed.....

Signed.....
Student Embalmer

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.